COMMITTEE REPORT

MADAM PRESIDENT:

The Senate Committee on Health and Provider Services, to which was referred Senate Bill No. 503, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 6, line 36, strike "shortfall" and insert "**supplemental payment**".

Page 6, line 40, strike "Payment for a state fiscal year ending after June 30,".

Page 6, strike line 41.

Page 6, line 42, strike "year's end.".

Page 7, line 9, strike "STEP SEVEN of".

Page 7, strike lines 10 through 12.

Page 7, line 13, strike "(b)." and insert "**this section.**".

Page 7, line 14, after "section" insert ".".

Page 7, line 14, strike "and as otherwise provided under".

Page 7, line 15, delete "IC 12-15-20-2(6).".

Page 7, line 17, strike "subsection (d)" and insert "**this section**".

Page 7, line 18, strike "STEP SEVEN of".

Page 7, line 22, strike "STEP".

Page 7, line 23, strike "SEVEN of".

Page 7, line 26, strike "STEP SEVEN of".

Page 7, line 32, strike "shortfall" and insert "**supplemental payment**".

Page 8, line 5, strike "shortfall" and insert "**supplemental payment**".

Page 9, line 16, strike "shortfall" and insert "**supplemental payment**".

Page 9, line 18, strike "Subject to subsection (e), the reimbursement for a state fiscal".

Page 9, strike line 19.

Page 9, line 20, strike "following the end of the state fiscal year.".

Page 9, line 22, strike "under subsection (d)." and insert "**by the hospital or on behalf of the hospital.**".

Page 9, line 29, strike "STEP SEVEN of".

Page 9, line 30, strike "In determining the percentage, the office shall apply the".

Page 9, strike lines 31 through 32.

Page 9, line 33, strike "(b).".

Page 9, line 34, after "section" insert "."

Page 9, line 34, strike "and as otherwise provided under".

Page 9, line 35, delete "IC 12-15-20-2(6).".

Page 9, line 37, strike "subsection (d)" and insert "**this section**".

Page 9, line 38, strike "STEP SEVEN of".

Page 9, line 42, strike "STEP".

Page 10, line 1, strike "SEVEN of".

Page 10, line 4, strike "STEP SEVEN of".

Page 10, line 10, strike "shortfall" and insert "**supplemental payment**".

Page 10, line 25, strike "shortfall" and insert "**supplemental payment**".

Page 11, line 1, after "2003," insert "**and before July 1, 2005,**".

Page 11, line 27, reset in roman "IC 12-15-20-2(8)(D)".

Page 11, line 27, delete "**IC 12-15-20-2(6)(D)**".

Page 12, strike lines 18 through 21.

Page 12, between lines 21 and 22, begin a new paragraph and insert:

"**(c) For state fiscal years ending after July 1, 2005, in addition to reimbursement received under section 1 of this chapter, a hospital eligible under this section is entitled to reimbursement in an amount calculated as follows:**

STEP ONE: The office shall identify the total inpatient hospital services and the total outpatient hospital services, reimbursable under this article and under the state Medicaid plan, that were provided during the state fiscal year by a hospital described in subsection (a).

STEP TWO: For the total inpatient hospital services and the total outpatient hospital services identified under STEP ONE, the office shall calculate the total payments made under this

article and under the state Medicaid plan to a hospital described in subsection (a), excluding payments made under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP THREE: The office shall calculate a reasonable estimate of the total amount that would have been paid by the office for the inpatient hospital services and the outpatient hospital services identified in STEP ONE under Medicare payment principles.

STEP FOUR: Subtract the amount calculated under STEP TWO from the amount calculated under STEP THREE.

STEP FIVE: Distribute an amount equal to the amount calculated under STEP FOUR to the eligible hospitals described in subsection (a) as follows:

(A) Subject to the availability of funds under IC 12-15-20-2(7) to serve as the non-federal share of the payments, the amount calculated under STEP FOUR for a state fiscal year shall be paid to all hospitals described in subsection (a). The payments shall be made on a pro rata basis based on the hospitals' Medicaid inpatient days or, if the federal Centers for Medicare and Medicaid Services do not approve that methodology, another payment methodology approved by the federal Centers for Medicare and Medicaid Services. For purposes of this clause, a hospital's Medicaid inpatient days are the hospital's in-state Medicaid paid claims and Medicaid managed care days for the state fiscal year referenced in STEP ONE, as determined by the office.

(B) Subject to IC 12-15-20.7, if the entirety of the amount calculated under STEP FOUR is not distributed following the payments made under clause (A), the remaining amount shall be paid to hospitals described in subsection (a) that are eligible under this clause. A hospital is eligible for a payment under this clause only if the hospital:

(i) has less than seventy thousand (70,000) Medicaid inpatient days annually;

(ii) was eligible for disproportionate share hospital payments under IC 12-15-19-2.1 for the state fiscal year ending June 30, 1998, or the hospital met the office's Medicaid disproportionate share payment criteria for payment under IC 12-15-19-2.1 based upon state fiscal year 1998 data and received a Medicaid disproportionate share payment for the state fiscal year ending June 30,

2001; and

(iii) received a Medicaid disproportionate share payment under IC 12-15-19-2.1 for state fiscal years 2001, 2002, 2003, and 2004.

The amount of a hospital's payment under this clause is subject to the extent that Medicaid indigent care trust funds are available or, if none are available, the non-federal share of the hospital's payment is provided by or on behalf of the hospital. The payment to each hospital shall equal the hospital's hospital specific limit provided under 42 U.S.C. 1396r-4 when the payments are combined with any other Medicaid payments made to the hospital. For state fiscal years ending before July 1, 2008, the total payments made under this clause may not exceed a total amount of sixty-eight million dollars ($68,000,000). For a state fiscal year ending after June 30, 2008, the total payments made under this clause may not exceed a total amount of sixty-eight million dollars ($68,000,000) plus the annual percentage growth in the state's aggregate Medicaid upper payment limit, as calculated by the office.

(C) Subject to IC 12-15-20.7, if the entirety of the amount calculated under STEP FOUR is not distributed following the payments made under clauses (A) and (B), the remaining amount may be paid to hospitals described in subsection (a) that are eligible under this clause. A hospital is eligible for a payment under this clause if the hospital:

(i) has less than seventy thousand (70,000) Medicaid inpatient days annually;

(ii) has received or is eligible to receive Medicaid disproportionate share payments under IC 12-15-19-2.1 for state fiscal years 2002, 2003, 2004, and for each state fiscal year after 2004; and

(iii) provides, or has provided on the hospital's behalf, the non-federal share of the hospital's payment.

A payment to a hospital under this clause is subject to the availability of non-federal dollars. The payment to each hospital shall not exceed ninety percent (90%) of the hospital's Medicaid shortfall. As used in this clause, Medicaid shortfall is the amount of the hospital's Medicaid costs less the hospital's Medicaid reimbursement and any payments received by the hospital under IC 12-15-15-9 and IC 12-15-15-9.5. For state fiscal years ending before July

1, 2008, the total payments made under this clause may not exceed a total amount of twenty-three million five hundred thousand dollars ($23,500,000). For a state fiscal year ending after June 30, 2008, the total payments made under this clause may not exceed a total amount of twenty-three million five hundred thousand dollars ($23,500,000) plus the annual percentage growth in the state's aggregate Medicaid upper payment limit, as determined by the office.

(D) Subject to IC 12-15-20.7, if the entirety of the amount calculated under STEP FOUR is not distributed following the payments made under clauses (A) through (C), the remaining amount shall be paid to hospitals described in subsection (a) that are eligible under this clause. A hospital is eligible for payment under this clause if the hospital provides, or has provided on the hospital's behalf, the non-federal share of the hospital's payment.

(E) As used in clauses (A) through (D), a hospital's Medicaid inpatient days are based on the hospital's Medicaid paid claims and Medicaid managed care days for the current state fiscal year, as determined by the office.".

Page 12, line 24, delete "." and insert "**or subsection (c).**".

Page 12, line 25, after "(b)" insert "**or subsection (c)**".

Page 12, line 28, after "(b)" insert "**or subsection (c)**".

Page 12, between lines 32 and 33, begin a new paragraph and insert:

"SECTION 8. IC 12-15-15-9 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 9. (a) For purposes of this section and IC 12-16-7.5-4.5, a payable claim is attributed to a county if the payable claim is submitted to the division by a hospital licensed under IC 16-21-2 for payment under IC 12-16-7.5 for care provided by the hospital to an individual who qualifies for the hospital care for the indigent program under IC 12-16-3.5-1 or IC 12-16-3.5-2 and:

(1) who is a resident of the county;

(2) who is not a resident of the county and for whom the onset of the medical condition that necessitated the care occurred in the county; or

(3) whose residence cannot be determined by the division and for whom the onset of the medical condition that necessitated the care occurred in the county.

(b) For each state fiscal year ending after June 30, 2003, **and before July 1, 2006,** a hospital licensed under IC 16-21-2 that submits to the division during the state fiscal year a payable claim under IC 12-16-7.5

is entitled to a payment under ~~this section.~~ **subsection (c).**

(c) Except as provided in section 9.8 of this chapter and subject to section 9.6 of this chapter, for a state fiscal year, the office shall pay to a hospital referred to in subsection (b) an amount equal to the amount, based on information obtained from the division and the calculations and allocations made under IC 12-16-7.5-4.5, that the office determines for the hospital under STEP SIX of the following STEPS:

STEP ONE: Identify:

(A) each hospital that submitted to the division one (1) or more payable claims under IC 12-16-7.5 during the state fiscal year; and

(B) the county to which each payable claim is attributed.

STEP TWO: For each county identified in STEP ONE, identify:

(A) each hospital that submitted to the division one (1) or more payable claims under IC 12-16-7.5 attributed to the county during the state fiscal year; and

(B) the total amount of all hospital payable claims submitted to the division under IC 12-16-7.5 attributed to the county during the state fiscal year.

STEP THREE: For each county identified in STEP ONE, identify the amount of county funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b).

STEP FOUR: For each hospital identified in STEP ONE, with respect to each county identified in STEP ONE, calculate the hospital's percentage share of the county's funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b). Each hospital's percentage share is based on the total amount of the hospital's payable claims submitted to the division under IC 12-16-7.5 attributed to the county during the state fiscal year, calculated as a percentage of the total amount of all hospital payable claims submitted to the division under IC 12-16-7.5 attributed to the county during the state fiscal year.

STEP FIVE: Subject to subsection (j), for each hospital identified in STEP ONE, with respect to each county identified in STEP ONE, multiply the hospital's percentage share calculated under STEP FOUR by the amount of the county's funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b).

STEP SIX: Determine the sum of all amounts calculated under STEP FIVE for each hospital identified in STEP ONE with respect to each county identified in STEP ONE.

(d) For state fiscal years beginning after June 30, 2006, a

hospital that received a payment determined under STEP SIX of subsection (c) for the state fiscal year ending June 30, 2006, shall be paid in an amount equal to the amount determined for the hospital under STEP SIX of subsection (c) for the state fiscal year ending June 30, 2006.

~~(d)~~ **(e)** A hospital's payment under subsection (c) **or (d)** is in the form of a Medicaid ~~add-on~~ **supplemental** payment. The amount of a hospital's ~~add-on~~ **Medicaid supplemental** payment is subject to the availability of funding for the non-federal share of the payment under subsection ~~(c).~~ **(f).** The office shall make the payments under ~~subsection~~ **subsections** (c) **and (d)** before December 15 that next succeeds the end of the state fiscal year.

~~(e)~~ **(f)** The non-federal share of a payment to a hospital under subsection (c) **or (d)** is funded from the funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) of each county to which a payable claim under IC 12-16-7.5 submitted to the division during the state fiscal year by the hospital is attributed.

~~(f)~~ **(g)** The amount of a county's transferred funds available to be used to fund the non-federal share of a payment to a hospital under subsection (c) **or (d)** is an amount that bears the same proportion to the total amount of funds of the county transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) that the total amount of the hospital's payable claims under IC 12-16-7.5 attributed to the county submitted to the division during the state fiscal year bears to the total amount of all hospital payable claims under IC 12-16-7.5 attributed to the county submitted to the division during the state fiscal year.

~~(g)~~ **(h)** Any county's funds identified in subsection ~~(f)~~ **(g)** that remain after the non-federal share of a hospital's payment has been funded are available to serve as the non-federal share of a payment to a hospital under section 9.5 of this chapter.

~~(h)~~ **(i)** For purposes of this section, "payable claim" has the meaning set forth in IC 12-16-7.5-2.5(b)(1).

~~(i)~~ **(j)** For purposes of this section:

(1) the amount of a payable claim is an amount equal to the amount the hospital would have received under the state's fee-for-service Medicaid reimbursement principles for the hospital care for which the payable claim is submitted under IC 12-16-7.5 if the individual receiving the hospital care had been a Medicaid enrollee; and

(2) a payable hospital claim under IC 12-16-7.5 includes a

payable claim under IC 12-16-7.5 for the hospital's care submitted by an individual or entity other than the hospital, to the extent permitted under the hospital care for the indigent program.

~~(j)~~ **(k)** The amount calculated under STEP FIVE of subsection (c) for a hospital with respect to a county may not exceed the total amount of the hospital's payable claims attributed to the county during the state fiscal year.".

Page 13, line 6, after "2003," insert "**but before July 1, 2006,**".

Page 13, line 14, strike "this section." and insert "**subsection (c).**".

Page 14, between lines 15 and 16, begin a new paragraph and insert:

"**(d) For state fiscal years beginning after June 30, 2006, a hospital that received a payment determined under STEP EIGHT of subsection (c) for the state fiscal year ending June 30, 2006, will be paid an amount equal to the amount determined for the hospital under STEP EIGHT of subsection (c) for the state fiscal year ending June 30, 2006.**".

Page 14, line 16, strike "(d)" and insert "**(e)**".

Page 14, line 16, after "(c)" insert "**or (d)**".

Page 14, line 17, strike "add-on" and insert "**supplemental**".

Page 14, line 19, strike "(e)." and insert "**(f).**".

Page 14, line 20, after "(c)" insert "**or (d)**".

Page 14, line 22, strike "(e)" and insert "**(f)**".

Page 14, line 23, after "(c)" insert "**or (d)**".

Page 14, line 25, strike "To the extent possible,".

Page 14, strike lines 26 through 41.

Page 14, line 42, strike "(f)" and insert "**(g)**".

Page 14, line 42, strike "(g)," and insert "**(h),**".

Page 15, line 3, strike "(g)" and insert "**(h)**".

Page 15, line 12, strike "(h)" and insert "**(i)**".

Page 15, line 15, delete "IC 12-15-20-2(6)(D)." and insert "**IC 12-15-20-2(8).**".

Page 15, line 16, strike "(i)" and insert "**(j)**".

Page 16, line 21, after "under" insert "**IC 12-15-16, IC 12-15-17, or IC 12-15-19 of**".

Page 16, line 31, strike "or".

Page 16, line 33, delete "." and insert "; **or**

(3) other permissible sources of non-federal share dollars.".

Page 16, between lines 40 and 41, begin a new paragraph and insert:

"SECTION 12. IC 12-15-19-2.1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 2.1. (a) For each state fiscal year ending on or after June 30, 2000, the office shall develop a disproportionate share payment methodology that ensures that each

hospital qualifying for disproportionate share payments under IC 12-15-16-1(a) timely receives total disproportionate share payments that do not exceed the hospital's hospital specific limit provided under 42 U.S.C. 1396r-4(g). The payment methodology as developed by the office must:

(1) maximize disproportionate share hospital payments to qualifying hospitals to the extent practicable;

(2) take into account the situation of those qualifying hospitals that have historically qualified for Medicaid disproportionate share payments; and

(3) ensure that payments net of intergovernmental transfers made by or on behalf of qualifying hospitals are equitable.

(b) Total disproportionate share payments to a hospital under this chapter shall not exceed the hospital specific limit provided under 42 U.S.C. 1396r-4(g). The hospital specific limit for a state fiscal year shall be determined by the office taking into account data provided by each hospital that is considered reliable by the office based on a system of periodic audits, the use of trending factors, and an appropriate base year determined by the office. The office may require independent certification of data provided by a hospital to determine the hospital's hospital specific limit.

(c) The office shall include a provision in each amendment to the state plan regarding Medicaid disproportionate share payments that the office submits to the federal Centers for Medicare and Medicaid Services that, as provided in 42 CFR 447.297(d)(3), allows the state to make additional disproportionate share expenditures after the end of each federal fiscal year that relate back to a prior federal fiscal year. However, the total disproportionate share payments to:

(1) each individual hospital; and

(2) all qualifying hospitals in the aggregate;

may not exceed the limits provided by federal law and regulation.

(d) ~~The office shall, in each state fiscal year, provide sufficient funds for acute care hospitals licensed under IC 16-21 that qualify for disproportionate share payments under IC 12-15-16-1(a). Funds provided under this subsection:~~

~~(1) do not include funds transferred by other governmental units to the Medicaid indigent care trust fund; and~~

~~(2) must be in an amount equal to the amount that results from the following calculation:~~

~~STEP ONE: Multiply twenty-six million dollars ($26,000,000) by the federal medical assistance percentage.~~

~~STEP TWO: Subtract the amount determined under STEP~~

~~ONE from twenty-six million dollars ($26,000,000).~~

A hospital that receives a payment under clause (B) of STEP FIVE of IC 12-15-15-1.5(c) is not eligible for a disproportionate share payment under this section.

SECTION 13. IC 12-15-19-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 6. (a) The office is not required to make disproportionate share payments under this chapter from the Medicaid indigent care trust fund established by IC 12-15-20-1 until the fund has received sufficient deposits to permit the office to make the state's share of the required disproportionate share payments.

(b) If:

(1) sufficient deposits have not been received; **or**

(2) the statewide Medicaid disproportionate share allocation is not sufficient to provide federal financial participation for the entirety of all eligible disproportionate share hospitals' specific limits;

the office ~~shall~~ **may** reduce disproportionate share payments **under IC 12-15-19-2.1** to ~~all~~ eligible institutions by ~~the same~~ **a** percentage **as long as, for each state fiscal year beginning after June 30, 2006, a hospital established under IC 16-22-8 receives at least sixty percent (60%) of the hospital's remaining hospital specific limit for each state fiscal year.** The percentage reduction shall be sufficient to ensure that payments do not exceed the **statewide Medicaid disproportionate share allocation or the** amounts that can be financed with the ~~state~~ **non-federal** share that is in the fund, **intergovernmental transfers, certifications of public expenditures, or other permissible sources of non-federal match.**".

Page 17, line 4, delete "," and insert "**and the total amount available for municipal disproportionate share payments in subsection (d),**".

Page 17, line 12, strike "the amount of".

Page 17, strike line 13.

Page 17, line 14, strike "IC 12-15-16-6 or sections 1 or 2.1 of this chapter." and insert "**all Medicaid payments, including Medicaid supplemental payments and other Medicaid disproportionate share payments received by the provider.**".

Page 17, line 22, strike "disproportionate share" and insert "**Medicaid supplemental**".

Page 17, line 23, strike "equals" and insert "**do not exceed**".

Page 18, line 8, delete "is forty million dollars ($40,000,000)." and insert "**may not exceed thirty-five million dollars ($35,000,000).**".

Page 18, between lines 8 and 9, begin a new paragraph and insert:

"SECTION 14. IC 12-15-19-10, AS AMENDED BY P.L.2-2005, SECTION 49, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 10. For state fiscal years beginning after June 30, 2000, **and ending June 30, 2003**, the state shall pay providers as follows:

(1) The state shall make municipal disproportionate share provider payments to providers qualifying under IC 12-15-16-1(b) until the state exceeds the state disproportionate share allocation (as defined in 42 U.S.C. 1396r-4(f)(2)).

(2) After the state makes all payments under subdivision (1), if the state fails to exceed the state disproportionate share allocation (as defined in 42 U.S.C. 1396r-4(f)(2)), the state shall make disproportionate share provider payments to providers qualifying under IC 12-15-16-1(a).

(3) After the state makes all payments under subdivision (2), if the state fails to exceed the state disproportionate share allocation (as defined in 42 U.S.C. 1396r-4(f)(2)), or the state limit on disproportionate share expenditures for institutions for mental diseases (as defined in 42 U.S.C. 1396r-4(h)), the state shall make community mental health center disproportionate share provider payments to providers qualifying under IC 12-15-16-1(c).".

Page 18, reset in roman lines 22 and 23.

Page 18, line 24, reset in roman "(7)".

Page 18, line 24, delete "(5)".

Page 18, line 25, after "(D)" insert ",".

Page 18, line 25, strike "and".

Page 18, line 25, delete "." and insert ", **and (8)(G).**".

Page 18, line 26, reset in roman "(8)".

Page 18, line 26, delete "(6)".

Page 19, line 23, after "2003," insert "**but before July 1, 2005,**".

Page 19, line 36, reset in roman "the non-federal share of payments to hospitals under".

Page 19, reset in roman line 37.

Page 19, line 38, reset in roman "under IC 12-15-15-9.5,".

Page 19, reset in roman lines 41 through 42.

Page 20, reset in roman lines 1 through 9.

Page 20, line 10, reset in roman "(F)".

Page 20, line 10, delete "(E)".

Page 20, line 11, delete "2006," and insert "**2005,**".

Page 20, line 29, delete "(F)" and insert "**(G)**".

Page 20, line 29, delete "2006," and insert "**2005,**".

Page 20, line 30, delete "entirety of the" and insert "**total amount of**".

Page 20, line 31, delete "for" and insert "**as follows:**

(1) Thirty million dollars ($30,000,000) shall be transferred to the office for the Medicaid budget.

(2) An amount not to exceed eleven million six hundred fifty thousand dollars ($11,650,000) to fund the non-federal share of payments to hospitals under IC 12-15-15-9 and IC 12-15-15-9.5.

(3) An amount not to exceed eight million nine hundred seventy-five thousand dollars ($8,975,000) to fund the non-federal share of payments to hospitals made under clause (A) of STEP FIVE of IC 12-15-15-1.5(c).

(4) To fund the non-federal share of payments to hospitals made under clause (B) of STEP FIVE of IC 12-15-15-1.5(c).

(5) To fund the non-federal share of payments to hospitals made under clause (C) of STEP FIVE of IC 12-15-15-1.5(c).

(6) To fund the non-federal share of disproportionate share payments to hospitals under IC 12-15-19-2.1.

(7) If additional funds are available after making payments under subdivisions (1) through (6), to fund other Medicaid supplemental payments for hospitals approved by the office and included in the state Medicaid plan.".

Page 20, delete lines 32 through 34.

Page 20, line 36, after "Sec. 2." insert "**(a)**".

Page 20, line 37, delete "year," and insert "year **ending before July 1, 2005,**".

Page 20, reset in roman line 39.

Page 20, line 40, reset in roman "(2) Second,".

Page 20, line 40, delete "(1) First,".

Page 20, line 42, reset in roman "(3) Third,".

Page 20, line 42, delete "(2) Second,".

Page 21, reset in roman line 3.

Page 21, line 4, reset in roman "(5) Fifth,".

Page 21, line 4, delete "(3) Third,".

Page 21, line 6, reset in roman "(6) Sixth,".

Page 21, line 6, delete "(4) Fourth,".

Page 21, reset in roman lines 8 and 9.

Page 21, between lines 9 and 10, begin a new paragraph and insert:

"**(b) For each state fiscal year ending after June 30, 2005, subject to section 3 of this chapter, the office shall make the payments identified in this section in the following order:**

(1) First, the payment under IC 12-15-20-2(8)(G).

(2) Second, payments under IC 12-15-15-1.1 and IC 12-15-15-1.3.

(3) Third, payments under IC 12-15-19-8.

(4) Fourth, payments under IC 12-15-15-9 and IC 12-15-15-9.5.

(5) Fifth, payments under clause (A) of STEP FIVE of IC 12-15-15-1.5(c).

(6) Sixth, payments under clause (B) of STEP FIVE of IC 12-15-15-1.5(c).

(7) Seventh, payments under clause (C) of STEP FIVE of IC 12-15-15-1.5(c).

(8) Eighth, payments under clause (D) of STEP FIVE of IC 12-15-15-1.5(c).

(9) Ninth, payments under IC 12-15-19-2.1 for disproportionate share hospitals.".

Page 21, line 32, after "program." insert "**The department of insurance and the office of the secretary shall provide oversight on the marketing practices of the program.**".

Page 21, between lines 40 and 41, begin a new paragraph and insert:

"**(d) The program must include the following in a manner and to the extent determined by the office:**

(1) Mental health care services.

(2) Inpatient hospital services.

(3) Prescription drug coverage.

(4) Emergency room services.

(5) Physician office services.

(6) Diagnostic services.

(7) Outpatient services, including therapy services.

(8) Disease management.

(9) Home health services.

(10) Urgent care center services.".

Page 24, line 25, after "Sec. 12." insert "**(a)**".

Page 24, between lines 39 and 40, begin a new paragraph and insert:

"**(b) An insurer or a health maintenance organization that has contracted with the office to provide health insurance under the program shall also offer to provide the same health insurance to the following:**

(1) An individual who has an annual household income that is:

(A) not more than two hundred percent (200%) of the federal income poverty level but the individual is not eligible for the program because of the individual's income

or because a slot is not available for the individual; or

(B) more than two hundred percent (200%) of the federal income poverty level.

(2) The employees of an employer if:

(A) the employees have an annual household income that is more than two hundred percent (200%) of the federal income poverty level; and

(B) the employer:

(i) has not offered employees health care insurance in the previous twelve (12) months; and

(ii) pays at least fifty percent (50%) of the premium for the employer's employees.

The state does not provide funding for coverage provided under this subsection.".

Page 25, line 19, delete "The" and insert "**Either:**

(A) the individual is no longer eligible for the program because the individual's annual household income exceeds the amounts set forth in section 5(a)(3) of this chapter; or

(B) the".

Page 27, delete lines 10 through 42.

Delete page 28.

Page 29, delete lines 1 through 33.

Page 30, line 21, delete "Except as provided in subsection (c), before" and insert "Before".

Page 31, line 1, reset in roman "IC 12-15-20-2(8)(D)".

Page 31, line 1, delete "IC 12-15-20-2(6)(D)" and insert "**or IC 12-15-20-2(8)(G)**".

Page 31, delete lines 8 through 24.

Page 31, line 25, reset in roman "(c)".

Page 31, line 25, delete "(d)".

Page 31, line 30, strike "(a) For purposes of this section,".

Page 31, strike line 31.

Page 31, line 32, strike "(b)" and insert "**(a)**".

Page 31, line 39, strike "(c)" and insert "**(b)**".

Page 31, line 39, reset in roman "first".

Page 31, line 39, after "payable" delete ",".

Page 31, line 39, reset in roman "in 2004,".

Page 31, line 40, after "2008," insert "**and each year thereafter,**".

Page 31, line 41, strike "product of:" and insert "**hospital care for the indigent program property tax levy for taxes first due and payable in the preceding calendar year multiplied by the statewide average assessed value growth quotient, using all the county**

assessed value growth quotients determined under IC 6-1.1-18.5-2 for the year in which the tax levy under this subsection will be first due and payable.".

Page 31, strike line 42.

Page 32, strike lines 1 through 15.

Page 33, between lines 9 and 10, begin a new paragraph and insert:

"SECTION 21. IC 27-8-5-16 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 16. Except as provided in sections 17 and 24 of this chapter, no policy of group accident and sickness insurance may be delivered or issued for delivery to a group that has a legal situs in Indiana unless it conforms to one (1) of the following descriptions:

(1) A policy issued to an employer or to the trustees of a fund established by an employer (which employer or trustees must be deemed the policyholder) to insure employees of the employer for the benefit of persons other than the employer, subject to the following requirements:

(A) The employees eligible for insurance under the policy must be all of the employees of the employer, or all of any class or classes of employees. The policy may provide that the term "employees" includes the employees of one (1) or more subsidiary corporations and the employees, individual proprietors, members, and partners of one (1) or more affiliated corporations, proprietorships, limited liability companies, or partnerships if the business of the employer and of the affiliated corporations, proprietorships, limited liability companies, or partnerships is under common control. The policy may provide that the term "employees" includes retired employees, former employees, and directors of a corporate employer. A policy issued to insure the employees of a public body may provide that the term "employees" includes elected or appointed officials.

(B) The premium for the policy must be paid either from the employer's funds, from funds contributed by the insured employees, or from both sources of funds. Except as provided in clause (C), a policy on which no part of the premium is to be derived from funds contributed by the insured employees must insure all eligible employees, except those who reject the coverage in writing.

(C) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(2) A policy issued to a creditor or its parent holding company or to a trustee or trustees or agent designated by two (2) or more creditors (which creditor, holding company, affiliate, trustee, trustees, or agent must be deemed the policyholder) to insure debtors of the creditor, or creditors, subject to the following requirements:

(A) The debtors eligible for insurance under the policy must be all of the debtors of the creditor or creditors, or all of any class or classes of debtors. The policy may provide that the term "debtors" includes:

(i) borrowers of money or purchasers or lessees of goods, services, or property for which payment is arranged through a credit transaction;

(ii) the debtors of one (1) or more subsidiary corporations; and

(iii) the debtors of one (1) or more affiliated corporations, proprietorships, limited liability companies, or partnerships if the business of the policyholder and of the affiliated corporations, proprietorships, limited liability companies, or partnerships is under common control.

(B) The premium for the policy must be paid either from the creditor's funds, from charges collected from the insured debtors, or from both sources of funds. Except as provided in clause (C), a policy on which no part of the premium is to be derived from the funds contributed by insured debtors specifically for their insurance must insure all eligible debtors.

(C) An insurer may exclude any debtors as to whom evidence of individual insurability is not satisfactory to the insurer.

(D) The amount of the insurance payable with respect to any indebtedness may not exceed the greater of the scheduled or actual amount of unpaid indebtedness to the creditor. The insurer may exclude any payments that are delinquent on the date the debtor becomes disabled as defined in the policy.

(E) The insurance may be payable to the creditor or any successor to the right, title, and interest of the creditor. Each payment under this clause must reduce or extinguish the unpaid indebtedness of the debtor to the extent of the payment, and any excess of the insurance must be payable to the insured or the estate of the insured.

(F) Notwithstanding clauses (A) through (E), insurance on agricultural credit transaction commitments may be written up to the amount of the loan commitment on a nondecreasing or

level term plan, and insurance on educational credit transaction commitments may be written up to the amount of the loan commitment less the amount of any repayments made on the loan.

(3) A policy issued to a labor union or similar employee organization (which must be deemed to be the policyholder) to insure members of the union or organization for the benefit of persons other than the union or organization or any of its officials, representatives, or agents, subject to the following requirements:

(A) The members eligible for insurance under the policy must be all of the members of the union or organization, or all of any class or classes of members.

(B) The premium for the policy must be paid either from funds of the union or organization, from funds contributed by the insured members specifically for their insurance, or from both sources of funds. Except as provided in clause (C), a policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members, except those who reject the coverage in writing.

(C) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(4) A policy issued to a trust or to one (1) or more trustees of a fund established or adopted by two (2) or more employers, or by one (1) or more labor unions or similar employee organizations, or by one (1) or more employers and one (1) or more labor unions or similar employee organizations (which trust or trustees must be deemed the policyholder) to insure employees of the employers or members of the unions or organizations for the benefit of persons other than the employers or the unions or organizations, subject to the following requirements:

(A) The persons eligible for insurance must be all of the employees of the employers or all of the members of the unions or organizations, or all of any class or classes of employees or members. The policy may provide that the term "employees" includes the employees of one (1) or more subsidiary corporations and the employees, individual proprietors, and partners of one (1) or more affiliated corporations, proprietorships, limited liability companies, or partnerships if the business of the employer and of the affiliated corporations, proprietorships, limited liability

companies, or partnerships is under common control. The policy may provide that the term "employees" includes retired employees, former employees, and directors of a corporate employer. The policy may provide that the term "employees" includes the trustees or their employees, or both, if their duties are principally connected with the trusteeship.

(B) The premium for the policy must be paid from funds contributed by the employer or employers of the insured persons, by the union or unions or similar employee organizations, or by both, or from funds contributed by the insured persons or from both the insured persons and one (1) or more employers, unions, or similar employee organizations. Except as provided in clause (C), a policy on which no part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance must insure all eligible persons, except those who reject the coverage in writing.

(C) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(5) A policy issued to an association or to a trust or to one (1) or more trustees of a fund established, created, or maintained for the benefit of members of one (1) or more associations. The association or associations must have at the outset a minimum of one hundred (100) persons, must have been organized and maintained in good faith for purposes other than that of obtaining insurance, must have been in active existence for at least one (1) year, and must have a constitution and bylaws that provide that the association or associations hold regular meetings not less than annually to further purposes of the members, that, except for credit unions, the association or associations collect dues or solicit contributions from members, and that the members have voting privileges and representation on the governing board and committees. The policy must be subject to the following requirements:

(A) The policy may insure members or employees of the association or associations, employees of members, one (1) or more of the preceding, or all of any class or classes of members, employees, or employees of members for the benefit of persons other than the employee's employer.

(B) The premium for the policy must be paid from funds contributed by the association or associations, by employer

members, or by both, from funds contributed by the covered persons, or from both the covered persons and the association, associations, or employer members.

(C) Except as provided in clause (D), a policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for the insurance must insure all eligible persons, except those who reject such coverage in writing.

(D) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(6) A policy issued to a credit union, or to one (1) or more trustees or an agent designated by two (2) or more credit unions (which credit union, trustee, trustees, or agent must be deemed the policyholder) to insure members of the credit union or credit unions for the benefit of persons other than the credit union or credit unions, trustee, trustees, or agent, or any of their officials, subject to the following requirements:

(A) The members eligible for insurance must be all of the members of the credit union or credit unions, or all of any class or classes of members.

(B) The premium for the policy shall be paid by the policyholder from the credit union's funds and, except as provided in clause (C), must insure all eligible members.

(C) An insurer may exclude or limit the coverage on any member as to whom evidence of individual insurability is not satisfactory to the insurer.

(7) A policy issued to cover persons in a group specifically described by another law of Indiana as a group that may be covered for group life insurance. The provisions of the group life insurance law relating to eligibility and evidence of insurability apply to a group health policy to which this subdivision applies.

(8) A policy issued to a trustee or agent designated by two (2) or more small employers (as defined in IC 27-8-15-14) as determined by the commissioner under rules adopted under IC 4-22-2.

SECTION 22. IC 27-8-5-17 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 17. (a) A group accident and sickness insurance policy shall not be delivered or issued for delivery in Indiana to a group that is not described in section 16(1)(A), 16(2)(A), 16(3)(A), 16(4)(A), 16(5)(A), 16(6)(A), ~~or~~ 16(7), **or 16(8)** of this chapter unless the commissioner finds that:

(1) the issuance of the policy is not contrary to the best interest of the public;

(2) the issuance of the policy would result in economies of acquisition or administration; and

(3) the benefits of the policy are reasonable in relation to the premiums charged.

(b) Except as otherwise provided in this chapter, an insurer may exclude or limit the coverage under a policy described in subsection (a) on any person as to whom evidence of individual insurability is not satisfactory to the insurer.".

Page 33, delete lines 36 through 39.

Page 35, between lines 28 and 29, begin a new paragraph and insert:

"SECTION 29. [EFFECTIVE UPON PASSAGE] **(a) As used in this SECTION, "small employer" means any person, firm, corporation, limited liability company, partnership, or association actively engaged in business who, on at least fifty percent (50%) of the working days of the employer during the preceding calendar year, employed at least two (2) but not more than fifty (50) eligible employees, the majority of whom work in Indiana. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one (1) employer.**

(b) The commissioner of the department of insurance and the office of the secretary of family and social services shall, not later than January 1, 2008, implement a program to allow two (2) or more small employers to join together to purchase health insurance, as described in IC 27-8-5-16(8), as amended by this act.

(c) The commissioner shall adopt rules under IC 4-22-2 necessary to implement this SECTION.".

Renumber all SECTIONS consecutively.

(Reference is to SB 503 as introduced.)

and when so amended that said bill do pass and be reassigned to the Senate Committee on Appropriations.

Committee Vote: Yeas 9, Nays 0.

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Senator Miller, Chairperson